SCOPE OF WORK - Money Follows the Person (MFP) Project

This Scope of Work presents the requirements and duties for administrative coordination, transition, and reporting services related to transitioning the Money Follows the Person (MFP) demonstration program participants from qualified institutional settings to home and community-based settings.

Administrative coordination includes, but is not limited to, tracking and reporting detailed MFP Candidate and Participant data, training transition team members and coordinating and organizing transition teams to provide transition services.

The Federally approved Operational Protocol for the Indiana MFP Demonstration Program, the Transition Manual and other approved documentation are incorporated into this Scope of Work by reference as the established procedures for implementation of the program. Where there is a conflict between these documents and the Scope of the Work, the conflict shall be resolved by following the requirements of the Operational Protocol. Where there is a conflict between this Scope of the Work and the terms of the federal grant, the terms of the federal grant take precedence.

A. Administrative Activities

1. **Referral Process** -Referral Process is a two (2) step process. The first step is a records review and the second step is a preliminary eligibility determination.

   For the records review, the Contractor will use data received from the Division of Aging and other sources to determine potential program eligibility of those interested in moving from a qualifying institution, to a home or community-based setting. The Contractor will review documentation provided by the nursing facility to screen for the individual's bio-psycho-social readiness and eligibility for MFP.

   If, after the records review, the individual is deemed eligible by the initial screening, the Contractor will schedule an Enrollment Meeting with each individual that meets the eligibility requirements and is believed to be safe for and capable of transition to the community.

   Billing for the referral process is allowed regardless if the individual meets eligibility.

2. **Enrollment Meeting** -A transition specialist will meet with the individual identified as eligible through the Referral Process. The individual's legal guardian, family member(s), and any others identified by the individual, will meet to learn about the MFP program and program eligibility requirements. The transition specialist will discuss Medicaid and home and community-based services (HCBS) eligibility requirements.

   The Contractor will verify Medicaid eligibility or arrange for referral for Medicaid eligibility. For individuals who are not Medicaid HCBS eligible, the Contractor will refer the individual to the appropriate agency for transition assistance.

   Once it is determined that the individual is eligible to participate in the MFP demonstration program, the individual/legal guardian will sign the consent form and the Contractor will schedule the start of targeted case management activities.

   Preliminary eligibility determination does not include any targeted case management activities and is a one-time billable event for each individual. Billing for the Enrollment Meeting is on a per individual basis.

B. Demonstration and Supplemental Services

Additional services are made available through the grant to facilitate transition, dependent upon the type of institution from which the individual is transitioning. These services are added to the service plan and cost comparison budget (CCB), and are only available during the 365 days of MFP program participation.

1. **Consultative Clinical Therapeutic Services** -Consultative clinical and therapeutic services that are not covered by Medicaid State Plan and are necessary to improve the participant's independence and inclusion in their community and to assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans.

2. **Flex Funds** -Flex funds are utilized only for PRTF MFP participants to purchase any of a variety of one-time or occasional goods and/or services needed for participants and their families, when the goods and/or services cannot be purchased by any other funding source, and the services or goods are directly related to the child/youth's service plan. Flex funds services and/or supports must be described in the person's service plan, and must be related to one or more of the following outcomes:
    a. success in school;
    b. living at the person's own home or with family;
    c. development and maintenance of personally satisfying relationships;
    d. prevention of or reduction in adverse outcomes, including arrests, delinquency, victimization and exploitation;
    e. becoming or remaining a stable and productive member of the community.

3. **Habilitation** -Habilitation services enhance participant functioning, life and social skills; prevent or reduce substance use/abuse; increase client competencies and build youth and family's strengths, resilience, and positive outcomes.

   This is accomplished through developing skills in identification of feelings; anger and emotional management; how to give and receive feedback; criticism and praise; problem-solving; decision making; assertive behavior; learning to resist negative peer pressure and develop pro-social peer interactions; improve communication skills; optimize developmental potential; address substance abuse and use issues; build and promote positive coping skills; learn how to have positive interactions with peers and adults, encourage therapeutic/positive play with or without parents/guardians, encourage positive community connections, and develop non-paid, natural supports for the child and family.

   Activities are to be conducted face-to-face with the client by a mentor or peer mentor and address the needs of the participant. Habilitation services do not include services that are mandated under IDEA.

4. **Non Medical Transportation** --Transportation services are available to enable MFP participants and their families to gain access to MFP program services and other community services, activities, and resources as specified in the service plan.

   This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under Medicaid State Plan, defined at 42 CFR 440.170(a) and does not replace them.

5. **Personal Emergency Response System (PERS)** -is to facilitate transition and provide a contact 24 hours a day, seven days a week. This is available to individuals transitioning from

nursing facilities only.

6. **Respite Care** -Respite Care services are provided in the least restrictive setting possible, to participants unable to care for themselves, on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant.

   Respite is not provided as a substitute for regular child care or to allow the parent/guardian to hold a job or attend school or classes.

7. **Targeted Case Management (TCM)** -The Contractor must provide targeted case management services to MFP participants, as needed. TCM services must be approved by the Division of Aging or its agent via a service plan.

   TCM responsibilities include, but are not limited to:
   a. Assessment of the clinical (medical and psychological), functional, and social needs of MFP program participants transitioning from qualified institutions. Assessments include:
      i. Participants transitioning from a nursing facility must have a Minimum Data Set – Home Care (MDS-HC) assessment within ninety (90) days of discharge;
      ii. Participants transitioning from a PRTF must have a Child Adolescent Needs and Strengths (CANS) assessment within ninety (90) days of discharge
      iii. Any other additional documentation regarding the transition of the individual.
   b. Development of transition service plans and Cost Comparison Budgets (CCBs).
   c. Completion of transition checklists.
   d. Arranging for other needed services and supports.
   e. Ensuring access to suitable housing.
   f. Education of participant
   g. Ensuring participants have an established medical provider and arrangements for filling prescriptions prior to being discharged from the qualified institution.
   h. Completion of all steps needed for a successful transition.
   i. Completion of post-transition quality assurance checklist during a face-to-face meeting.

   For MFP successful transitions, TCM must be rendered within one hundred eighty (180) days prior to discharge to the community. TCM services cannot be billed until after the individual has transitioned to the community.

8. **Training and Support for Unpaid Caregivers**-Training and support services are available for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, co-worker, or companion who provides uncompensated care, training, guidance, companionship, or support to a child/youth served in the MFP program.

9. **Wraparound Facilitation** -Wraparound Facilitation is a planning process that follows a series of steps and is provided through a Child and Family Wraparound Team. The Wraparound Team is responsible for assuring that the participant's needs and the entities responsible for addressing them are identified in a written service plan.

   The individual who facilitates and supervises this process is the *Wraparound Facilitator*.

10. **Wraparound Technician** -The Wraparound Technician applies the theories and concepts of the wraparound process and the resulting service plan to the child/youth's day to day activities. Wraparound Technicians are guided and supervised by the Wraparound Facilitator. They discuss

progress with other team members, providers, and family and make recommendations to the Wraparound Facilitator and team.

Wraparound Technician may not duplicate Wraparound Facilitation or any other MFP or Medicaid State Plan service. However, the Wraparound Technician functions may be provided by the same individual who provides Wraparound Facilitation services.

C. Definitions and Terms

1. **Business Day** -Business day refers to Monday through Friday during the posted hours of operation for the Contractor, unless Saturdays and Sundays are needed to complete the transition activities. State of Indiana holidays are not business days and are listed at: http://www.in.gov/spd/2555.htm

2. **Case Management** – The Contractor must employ a social worker or otherwise qualified individual as defined in the Operational Protocol, who provides case management services to MFP participants. Case managers must meet the same qualifications as the transition specialist. The responsibilities of case management are listed in Section F of this document. In addition:

    a. The Contractor's transition specialist must meet with the client a minimum of one time each week for no less than six weeks, to ensure that the individual is doing well in his or her new environment. The meetings are to be provided in the six weeks immediately following transition, with the first face-to-face meeting taking place within 24 hours of transition.
    b. On-going case management will occur as decided by the team but will be no less than a face-to-face contact every 90 days.
    c. For individuals transitioning from Psychiatric Residential Treatment Facilities, the Contractor will attend the first meeting post transition, which will occur within 24 hours after transition, and then pass case management responsibilities to the Wraparound Facilitator.

3. **Failed Transition** -A failed transition is when an individual is deemed eligible and does not transition. Failed transitions are not eligible for TCM payment, and do not count toward meeting required transition benchmarks.

4. **Health Care Coordination** -This service is medical coordination by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) to manage the health care of the individual transitioning from a nursing facility. Health Care Coordination includes physician consults, medication ordering, development and nursing oversight of a healthcare support plan, and other necessary services.

    The purpose of Health Care Coordination is to provide for the stabilization, prevention of deterioration, management of chronic conditions and improvement of health status.

    Health Care Coordination requires a minimum of one (1) face-to-face visit per month, not to exceed eight (8) hours per month.

    Health care coordination services will not duplicate services provided under Medicaid State Plan or any other services.

    This service is added to the service plan and CCB when deemed necessary.

5. **MFP Eligibility Requirements** -The Contractor will provide transition services for individuals who have received institutional care from a qualifying institution, for a continuous stay of ninety (90) consecutive days; and who are Medicaid eligible for at least one day prior to discharge to the community, who are eligible for one of the MFP participating programs, and who will be transitioning to a qualified community-based setting.

6. **MFP Candidate (Candidate)** -A MFP candidate is any individual who meets MFP eligibility requirements and wants to leave a qualified institutional setting for a qualified community-based setting.

7. **MFP Participant (Participant)**-A MFP participant is any individual who has been identified as meeting MFP eligibility requirements, chooses to participate in the MFP program as indicated by a signed informed consent form, and is being or has been transitioned from a qualifying institution to a qualified home and community-based setting.

8. **Qualified Community-Based Setting** -A qualified community-based setting is a home owned or leased by the individual or the individual's family member or an apartment with an individual lease. A qualified community-based setting must have lockable access and egress and include living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.

   For individuals transitioning from nursing facilities, qualified community-based settings include apartments available in HUD subsidized housing complexes or congregate housing complexes that accommodate elders and individuals with special needs, or a residence, in a community-based residential setting, such as an adult family care home in which no more than four (4) unrelated individuals reside.

   Assisted living facilities may also be considered a community-based setting for purposes of the MFP demonstration program. The assisted living facility must allow aging in place, where a resident's contract may not be terminated due to declining health or increased care needs and meet the MFP definition of a qualified community- based setting.

9. **Qualifying Institution** – Indiana's MFP Operational Protocol states the following comprehensive care facilities are Qualifying Institutions:
   a. Nursing facilities
   b. Psychiatric residential treatment facilities (PRTFs)
   c. State Operated Facilities (SOFs)

10. **Successful Transition** -Any transition of an individual from a qualifying institution to a home and community-based setting.

11. **Transition Nurse** -The Contractor must employ a nurse who provides clinical consultation and care to MFP participants. The transition nurse may be a Registered Nurse with a minimum of one year's full-time, direct service experience with the elderly or persons with disabilities. This experience includes assessment, service plan development, and monitoring.

    Or, the transition nurse may be a Licensed Practical Nurse possessing the following qualifications:
    a. A Bachelor's Degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or
    b. A Bachelor's Degree in any field with a minimum of two years full-time, direct service experience with the elderly or persons with disabilities. This experience includes assessment, service plan development, and monitoring.

A Master's Degree in a related field may substitute for the required experience.

12. **Transition Specialist** -The Contractor must employ a social worker or otherwise qualified individual as defined in the Operational Protocol, who provides transition services to MFP participants.

    The transition specialist must possess a Bachelor's Degree in Social Work, Psychology, Sociology, Counseling, Gerontology, or Nursing; or
    a. Be a Registered Nurse with a minimum of one year's full-time, direct service experience with the elderly or persons with disabilities, including assessment, service plan development, and monitoring; or
    b. Possess a Bachelor's Degree in any field with a minimum of two years full-time, direct service experience with the elderly or persons with disabilities, including assessment, service plan development, and monitoring.

    A Master's Degree in a related field may substitute for the required experience.

13. **Transition Team** -The team is comprised of at least the MFP participant, their legal guardian (if applicable), a Transition Specialist, a Transition Nurse, and any other individual of the participant's choosing.

14. **Wraparound Facilitator (WF)** - The individual who facilitates and supervises the Wraparound process, guides the Child and Family Wraparound Team, and assures that the needs and supports for a participant are identified and addressed in the participant's written service plan.

D. DUTIES OF THE DIVISION OF AGING

1. The Division of Aging (DA) will notify the Contractor within seven (7) business days of any changes CMS requires for this contract.
2. The DA will identify potential program participants using processes including, but not limited to, thorough analysis of internal and external data. The DA will send the information, as well as any other data analysis that has been determined by the DA to yield a viable group of potential candidates, to the Contractor within seven (7) business days of receipt of the listing.
3. The MFP Program Director and the Contractor's MFP Project Manager are both responsible for the timely exchange of pertinent information.
4. The DA will approve the number of individuals to be transitioned and will notify the Contractor if there is a change in the number of individuals to be transitioned.

E. DUTIES AND RESPONSIBILITIES OF CONTRACTOR

1. Adhere to all policies established by
    a. the MFP Program, including the Operational Protocol and Transition Manual
    b. the DA
    c. the Office of Medicaid Policy and Procedure (OMPP)
2. Comply with all changes to the MFP program required by the Centers for Medicare and Medicaid Services (CMS), including programmatic, reporting, or regulation changes.
    a. Any change by CMS may require a renegotiation or amendment to this contract.
3. Implement the policies established by
    a. the MFP Program, including the Operational Protocol and Transition Manual
    b. the CMS
    c. the DA

4. Meet the responsibilities as detailed in this document.
    a. Subcontracting of stated responsibilities is subject to review and approval by the Division of Aging.
5. Appoint a MFP Project Manager to act as the liaison between the Contractor and DA.
6. Coordinate exchange of information on MFP Candidates and Participants between the DA and the Contractor.
    a. Confirm receipt of MFP candidate referrals within one (1) business day of receiving the referral.
    b. TCM activities, for individuals who choose to transition, must start within two (2) business days of the consent form being signed.
    c. Report pertinent information to DA per requirements of DA and CMS.
7. Submit claims for the previous month's administrative activities, as defined in this contract.
    a. The Contractor is responsible for ensuring detailed supporting documentation submitted with the monthly claim and is maintained and available upon request.
    b. Referral Process - Documentation consists of details of all clients being claimed, including:
        i. Client names and other identifying information;
        ii. Clients for whom referral receipt was confirmed in one (1) business day; and
        iii. Clients who are contacted and for whom an Enrollment Meeting is scheduled within seven (7) business days of the initial contact with the Candidate.
    c. Enrollment Meeting - Documentation consists of details of all clients being claimed, including:
        i. Client Names -Full listing and other identifying information;
        ii. Clients who have signed the consent form and have met with a Transition Specialist or Transition Nurse; and
        iii. Names of clients who have declined participation.
8. Submit an administrative claim for payment to the FSSA Division of Aging by the 30th of the month for the previous month's activities.
9. The Contractor shall pay their subcontractors within five (5) business days of receiving payment from the Division of Aging.
10. Ensure that all Case Managers, Transition Specialists, and Transition Nurses are trained in MFP program processes.
    a. No one shall perform MFP services until their training is complete.
    b. Minimum training for all transition team members shall include the following subjects:
        i. MFP program Transition Manual;
        ii. MDS-HC software and assessment process;
        iii. Case Management Orientation;
        iv. Operational Protocol;
        v. Self directed care option;
        vi. HCBS, including HCBS waivers and other service options;
        vii. The Long Term Care Ombudsman program;
        viii. the Adult Protective Services program;
        ix. the Quality Management system for MFP program participants; and
        x. the Wraparound facilitation process.
    c. In appropriate situations, webinars, conference calls and other technological devices may be utilized for training purposes.
11. Monitor caseloads of all Case Managers, Transition Specialists, and Transition Nurses working with MFP participants.
    a. The ratio to MFP participants shall be no more than an annual statewide average of one (1) MFP case manager to twenty-five (25) MFP participants.
    b. MFP case managers may not provide case management services to non-MFP

participants if the total caseload will exceed (1) case manager to twenty-five (25) cases.

12. The Executive Director or MFP Program Manager of the Contractor shall participate in scheduled meetings with DA and key stakeholders
13. Ensure that confidential data exchanged between the DA, Contractor and Subcontractors comply with all state and federal HIPAA requirements.
14. Coordinate with the Division of Aging when gaps or inconsistencies in data are identified.
15. Develop monthly reporting and monitoring protocol for administrative activities which include:
    a. All referral process activities.
    b. All referrals of potential MFP candidates and acknowledge receipt of referral with the referral source within one (1) business day of receipt.
    c. All TCM activities for individuals who choose to transition within a maximum of seven (7) business days after the consent form is signed.
16. Schedule the Enrollment Meeting within seven (7) business days of the initial contact with the candidate.
17. Contractors will conduct the following post-transition activities:
    a. A Transition Specialist or Transition Nurse must schedule and perform, in person, a follow-up visit within twenty-four (24) hours after discharge.
    b. A Transition Specialist or Transition Nurse must schedule a minimum of six (6) weekly contacts immediately following the discharge of a Participant from a nursing facility.
        i. At least three (3) of these must be face-to-face.
        ii. The initial visit being face-to-face and taking place no later than twenty-four (24) hours after discharge.
    c. A Transition Specialist or Transition Nurse and a Wraparound Facilitator must together perform the initial visit face-to-face within twenty-four (24) hours after discharge of any Participant who transitions from a PRTF or SOF.
18. Should the Contractor choose to subcontract transition responsibilities, the Contractor must incorporate the following list of responsibilities in each of its subcontracts:
    a. Provide Targeted Case Management (TCM).
    b. Complete required reports and communicate results in monthly reports to the Contractor.
    c. Employ Transition Specialists and Transition Nurses to provide transition services that meet the requirements and needs of the MFP program.
    d. Ensure that Transition Specialists and Transition Nurses possess the appropriate licensing or educational status requirements.
    e. Ensure that case managers meet the same qualifications as the transition specialist.
    f. Ensure that caseloads for transition specialists, case managers and nurses working with MFP participants meet the annual statewide ratio of no more than one (1) case manager for each twenty-five (25) cases.
    g. Establish outreach with community providers, such as the Centers for Independent Living, and other community groups to enhance the availability of resources, including an up-to-date database or listing of community-based services in their respective area.
    h. Participate in continuous quality improvement activities to enhance quality assurance and create systemic efficiencies.
19. If subcontracting, the Contractor shall ensure that each Subcontractor performs and is paid for Administrative Activities as per the scope of this contract.
20. The Contractor shall ensure that funds are distributed among any Subcontractors for services rendered and in accordance with the contract.
21. Changes in a subcontractor must be reported to the Division of Aging immediately.
22. Contractor shall provide necessary translation and communication services for clients requiring a language other than spoken English.
23. Contractor staff shall not:
    a. Enter into a power-of-attorney relationship with a transition candidate.

b. Enter into a surrogate decision-making or guardianship relationship with a transition candidate.
c. Enter into a health care representative relationship with a transition candidate.
d. Have any involvement with the transition candidate's personal finances.
e. Coerce or force transition candidates against their will.
f. Act on behalf of or for any other party, besides the actual transition candidate.
g. Work in an impaired or intoxicated state.
h. Abuse the relationship with the transition candidate.
i. Rely on hearsay from any associated person regarding the ability of the transition candidate to successfully move back into a home or community based setting.

F. TRANSITION AND CASE MANAGEMENT RESPONSIBILITIES

The MFP transition specialists, nurses, and case managers must:

1. Assess the health and long-term care needs of each participant objectively;
2. Support a complete and timely planning process directed by the participant;
3. Complete pre-transition, discharge, and post-transition checklists, making certain that all necessary services and supports, paid and unpaid, are available to support a safe transition;
4. Prepare plans that ensure that back up services are available 24 hours a day, seven (7) days a week;
5. Ensure community-based needs are met after discharge from the qualified institution during the six (6) weeks post transition period and until participant selects and is transferred to a post-transition case manager; and
6. Ensure the individual has access to necessary supports and services before completing the transfer to a home and community-based case manager.

G. QUALITY ASSURANCE PROCESS AND QUALITY MONITORING

1. The Money Follows the Person Rebalancing Demonstration Grant specifies four (4) quality assurance areas for which information must be reported, or systems must be developed, managed, and monitored by the Contractor, including:
    a. Twenty-four (24) hour back-up system;
    b. Individual assessments to identify personal areas of risks (for example, memory, falls, etc.);
    c. Specific risk reduction and avoidance plans for each person; and
    d. Incident reporting using DA's existing system for incidents.
2. The Contractor must, at a minimum, report instances of the events listed in 460 IAC 1.2-8-2.
3. The Contractor will also monitor the following areas:
    a. Participant access to community-based services and supports identified in the assessment.
    b. Participant-centered service planning and delivery, including free choice of provider.
    c. Participant safeguards through individual risk assessments and risk avoidance plans; on-going monitoring by case manager and POC reviews.
    d. Participant's rights and responsibilities are safeguarded.
    e. Participants must be allowed to accept or refuse services or service providers.

H. REPORTING AND PERFORMANCE REQUIREMENTS

1. The Contractor will provide reports to the Division of Aging's MFP Program Director in a format developed by the Contractor and approved by the Division of Aging.
2. The Contractor's Program Manager will compile information and submit it to the Division of Aging's MFP Program Director in a format developed by the Contractor and approved by the Division of Aging.
3. Required reporting information includes, but is not limited to:
    a. **Monthly Administrative Data** is due the 15th day of each month, for the previous

month (i.e., due by February 15 for January's monthly data).

i. Number and type of networking and stakeholder meetings that the Executive Director or Program Manager attended.
ii. Number and types of Contractor-provided trainings that Contractor staff or Subcontractors attended.
iii. Report to the MFP program (i.e., MFP Program Director, Program Coordinator) the names of the Contractor's Staff that have left the Contractor's employment or changed jobs within the Contractor's organization.
iv. Number and type of gaps identified by the Contractor or Subcontractor in community resources and any efforts made to fill such gaps.

b. **Monthly Transition Data** is due the 15th of each month for the previous month (i.e., due by February 15 for January's monthly data). Transition data will include all potential MFP candidates regardless of referral source.

i. Statistics or summary reporting regarding efficiency and overall operations
- Information related to informed consent or guardianship (i.e., difficulty in receiving informed consent, interaction with and role of guardians, etc).
- Use of a twenty-four (24) hour backup system that is developed and monitored by the Contractor and the reason it was used (for example, for emergency transportation, life support equipment repair, critical health services, etc). This does not include the Personal Emergency Response System.
- Percentage of use of a twenty-four (24) hour backup system that is developed and monitored by the Contractor for which assistance was needed and was provided.
- If assistance was not provided for use of a twenty-four (24) hour backup system that is developed and monitored by the Contractor, the reason the assistance was not provided.
- Contractor or Subcontractor-initiated incident reporting for MFP participants. Contractor and its subcontractors must, at a minimum, report instances of the events listed in 460 IAC 1.2-8-2.
- Track unplanned events that may interrupt participation in the MFP program, including but not limited to hospitalizations or any return institutionalizations.
- Maintain receipts regarding what each MFP participant elects to purchase using the community transition funding benefit, and identify any consistent use or needs across participants.
- Barriers to recruitment of MFP participants.
- Barriers to obtaining informed consent.
- Recommendations for improving program performance.

ii. Status report from transition specialist and transition nurse that identifies contact with participants, issues, and barriers to transition.
iii. The number of MFP transition candidate contacts and assessments.
iv. Number of referrals and MFP participants, listed by referral source (self, outreach, use of MDS data, etc)
- Number of candidates in the Referral Process
- Number of MFP participants during reporting period.

v. Number of successful transitions implemented by population.
- Cumulative number of transitions.
- Number of failed transitions by population.
- Reason for failed transitions.
- For each successful transition, length of time between assessment to transition.

vi. Number of MFP participants re-institutionalized, and reason for re-

institutionalization.

vii. Number of MFP participants who completed one-year transition period.

c. **Quarterly Report Data** is due within fifteen (15) calendar days after the end of each quarter. Transition data will include all potential MFP candidates regardless of referral source.

i. Project cumulative hours of Targeted Case Management worked per individual client for both MFP and non-MFP candidates, with indication of number of hours actually billed.
ii. Participant data consistent with the CMS Participant Data File.
iii. Report findings of state-wide case load ratio monitoring.
iv. The cumulative number of MFP and candidate contacts and assessments.
v. Number of MFP referrals, by source (self, outreach, use of MDS data).
vi. Number of people receiving (billed for) Referral Process activities.
vii. Number of MFP participants during reporting period.
viii. Number of successful transitions implemented.
ix. Cumulative number of transitions.
x. Number of failed transitions.
xi. Reason for failed transitions.
xii. Number of MFP participants re-institutionalized.
xiii. Number of MFP participants who completed one-year transition period.
xiv. For each successful transition, length of time between assessment and transition.

d. **Semi-Annual Report Data,** as required by CMS, is due to the Division of Aging within fifteen (l5) calendar days after January 1 and June 30.

e. Annual report of the results of the Stakeholder Satisfaction Surveys (derived from surveys created by Contractor).

f. Changes or updates to MFP related subcontracts for Contractor.

g. Other reports as requested or required by the DA or CMS or OMPP

I. TRANSITION GOALS and BILLING REQUIREMENTS

1. Qualified Transition Goals

a. The Contractor may bill on a monthly basis if the monthly goal has been met or exceeded;
b. If the monthly transition goals have not been met, the contractor may not bill for that month.
c. A quarterly review may be conducted to determine if the monthly transition goals in total have been met. If the quarterly monthly totals have been met, the contractor may bill for previous months that were not claimed.
d. If this contract is extended, the benchmarks and goals for the project will be updated.

2. Annual Total Transition Goal

a. The Annual Total Transition Goal is the sum of the **Qualified Transition Goals** for an entire State Fiscal Year. .
b. At the end of the State Fiscal Year, if the **Annual Total Transition Goal** has been achieved, the Contractor may perform an end-of-year reconciliation, addressing previously unclaimed months.

Table 1. Qualified Transition Goals

Qualified Transition Goals	
Benchmark Month	**End of Month QTG**
July 2013	37
August 2013	36
September 2013	36
October 2013	34
November 2013	31
December 2013	22
January 2014	20
February 2014	26
March 2014	33
April 2014	34
May 2014	34
June 2014	34
July 2014	37
August 2014	36
September 2014	36
October 2014	33
November 2014	30
December 2014	22
January 2015	20
February 2015	25
March 2015	33
April 2015	35
May 2015	35
June 2015	35

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Benchmark Month	**End of Month QTG**
July 2015	37
August 2015	36
September 2015	35
October 2015	35
November 2015	31
December 2015	23
January 2016	20
February 2016	25
March 2016	33
April 2016	35
May 2016	35
June 2016	35